TRICARE Fundamentals Course

Glossary

Participant Guide

Allowable Charge	The amount on which TRICARE Standard figures the cost-share for covered care. TRICARE Standard figures the allowable charge from all professional (non-institutional) providers' bills nationwide, with adjustments for specific localities, over the last year. The claims processor can tell a provider the allowable charge amount for specific services or procedures.
Adjunctive Dental Care	Dental care that is medically necessary in the treatment of an otherwise covered medical (not dental) condition and is an integral part of the treatment of such medical condition.
Authorized Provider	A doctor or other individual authorized to provider of care, hospital or supplier who has applied to, and been approved by, TRICARE to provide medical care and supplies. Generally, that means the provider is licensed by the state, accredited by a national organization, or meets other standards of the medical community. If a provider isn't authorized, TRICARE cannot help pay the bills.
Balance Billing	Balance billing is the provider billing a beneficiary for the rest of its charges after the beneficiary's civilian health insurance plan or TRICARE has paid everything it is going to pay. Federal law says the beneficiary is not legally responsible for amounts in excess of 15 percent above the TRICARE allowable charge.
Beneficiary	A person who is eligible for TRICARE benefits. Beneficiaries include active duty service members, active duty family members, retired service members and their families. Family members include spouses and unmarried natural or stepchildren up to the age of 21 (or 23 if full-time students at accredited institutions of learning
Billed Charge	A billed charge is the total cost of care, without discounts or reduced fees from a provider.
Catastrophic Cap	A cost "cap" or upper limit has been placed on TRICARE Standard-covered medical bills in any fiscal year. The limit that an active duty family will have to pay is $1,000; the limit for all other TRICARE Standard-eligible families is $3,000.
Catchment Area	An area defined by ZIP codes that generally falls within a 40-mile radius of an inpatient Military Treatment Facility (MTF). This is different from the 50-mile radius of the TRICARE Prime Remote (TPR) benefit. To be eligible for TPR, participants must live and work outside a 50-mile radius around or approximately one hour's drive time from an MTF.
Co-payment	This is a fixed amount you'll pay when you're enrolled in TRICARE Prime and you visit a CONUS civilian provider for some type of medical care.

Cost Share	The percentage you pay – and the part TRICARE Standard pays – of the allowable charges for care on each claim. The cost share depends on the sponsor's status (active or retired) in the service.
Deductible	The amount the beneficiary must pay on his/her bills each year toward their outpatient medical care, before TRICARE begins sharing the cost of medical care. The beneficiary pays the provider the first $150 for an individual, or $300 for a family, worth of medical bills each fiscal year – from October 1 through September 30 (for the families of active duty members in pay grade E-4 and below, the deductible amounts are $50 for an individual and $100 for a family). The contractor keeps track of the beneficiary's deductible and subtracts it from claims during the year. How much a beneficiary has paid toward the deductible is spelled out on the Explanation of Benefits. The deductible is separate from, and in addition to, the cost share.
Demonstration Project	A "demonstration project" is a project of limited duration designed to test a different method for the finance, delivery or administration of health care activities for the uniformed services. Demonstration projects may be required or authorized by 10 U.S.C. 1092, any other statutory provision requiring or authorizing a demonstration project.
Emergency Services	Medical services provided for a sudden or unexpected medical or psychiatric condition, or the sudden worsening of a chronic (ongoing) condition that is threatening to life, limb, or sight and needs immediate medical treatment, or which has painful symptoms that need immediate relief to stop suffering.
Enrollee	A TRICARE eligible beneficiary who has elected to enroll in TRICARE Prime, TRICARE Prime Remote, or TRICARE Prime Remote for Active Duty Family Members.
Explanation of Benefits (EOB)	A statement the TRICARE contractor sends the beneficiary and the provider who participates in TRICARE that shows who provided the care, the kind of covered service or supply received, the allowable charge and amount billed, the amount TRICARE Standard paid, how much of the deductible has been paid, and the cost share. It also gives the reason for denying a claim.

Health Care Finder (HCF)	A registered nurse or designee in the TRICARE Service Center who will help you make an appointment with a provider in the MTF or assist you in getting care with a TRICARE authorized provider. This service is available by telephone 24 hours a day, 365 days a year.
Military Treatment Facility (MTF)	Shorthand for all uniformed services hospitals and clinics including the several former Public Health Service hospitals that are now called "designated providers" under TRICARE.
Network Provider	Care provided by the network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. Thus a "network provider" is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor.
Non-authorized Provider	A provider of care who is not authorized under TRICARE might be someone like a chiropractor or an acupuncturist (classes of providers that are not recognized by TRICARE because the care they provide is outside the scope of TRICARE's benefit structure). Or it might be a physician who does not meet state licensing or training requirements, or who has not sought, or who has rejected, authorization to treat TRICARE-eligible patients.
Non-network Provider	Any care not provided by "network providers" except care provided to a TRICARE Prime enrollee by a "non-network provider" upon referral from the contractor. A "non-network provider" is one who has no contractual relationship with the prime contractor to provide care to TRICARE beneficiaries. A "non-network claim" is one submitted for "non-network care."
Non-participating Provider	A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a TRICARE beneficiary, but who did not agree on the TRICARE claim form to participate or to accept the TRICARE determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider.

Other Health Insurance (OHI)	If the beneficiary has other health care coverage besides TRICARE through an employer, an association, or a private insurer, or if a student in the family has a healthcare plan obtained through his or her school – that's what TRICARE considers "other health insurance". It may also be called "double coverage" or "coordination of benefits." It doesn't include TRICARE supplemental insurance. It also does not include Medicaid.
Participating Provider	Health care providers who "participate" in TRICARE, also called "accepting assignment," agree to accept the TRICARE allowable charge (including your cost share and deductible, if any) as the full fee for your care. Individual providers can participate on a case-by-case basis. They file the claim for you and receive the check, if any, from TRICARE. Hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient care. For outpatient care, hospitals may or may not participate.
Point of Service (POS)	When the beneficiary refers himself/herself for non-emergency specialty or inpatient care, they will have to pay higher costs. To avoid paying this higher cost, call the PCM or HCF for a pre-authorization. The point of service option does not apply to emergency care.
Primary Care Manager (PCM)	An individual, group practice, or clinic that is part of the TRICARE Prime Network and that is also responsible for providing primary health care services and referrals for specialty care.
Prior Authorization	A review determination made by a licensed professional nurse or paraprofessional for requested services, procedures, or admissions. Prior authorizations must be obtained prior to those services being rendered.
Professional Fees	Professional fees are charges for medical professionals that the hospitals or third-party payers require to be separately identified on the billing form.
Provider	A doctor, hospital, or other person or place that delivers medical services or supplies.
Referral	The process by which a primary care manager (PCM) refers a TRICARE Prime beneficiary to another professional or ancillary provider for specialized medical services, prior to those services being rendered.

Region	A geographic area determined by the government for civilian contracting of medical care and other services for TRICARE eligible beneficiaries.
Reserve Component (RC)	The RC includes the Army National Guard, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the U.S. Coast Guard Reserve.
Routine Care	General outpatient (sick call) visits to a doctor, including laboratory tests and x-rays as well as preventive diagnosis health care.
Specialty Care	Generally defined as care the Primary Care Manager is not able to provide.
Split Enrollment	Refers to multiple family members enrolled in TRICARE Prime under different Regions/contractors, including managed care support contractors and Uniformed Services Family Health Plan designated providers.
Service Point of Contact (SPOC)	A person or Uniformed Services office responsible for coordinating civilian health care for active duty DoD, USPHS and NOAA, and Coast Guard members participating in TRICARE Prime Remote. A SPOC is responsible for reviewing a Service Members' specialty and inpatient medical care authorizations for potential "fitness for duty" medical conditions. SPOCs are members of the Armed Forces (Army, Navy, Air Force, Marines, and Coast Guard) stationed at the Military Medical Support Office (MMSO), Great Lakes, Illinois. USPHS and NOAA SPOCs are members of the Beneficiary Medical Program Office.
Sponsor	The uniformed service person – either active duty, retired, or deceased – whose relationship to the beneficiary makes them eligible to TRICARE.
TRICARE Service Center (TSC)	A customer service center for beneficiaries, operated by the regional TRICARE managed care support contractor. TRICARE Prime Remote members can get information and help at the nearest TSC within their region. Beneficiary Service Representatives and Health Care Finders are located at the TSC to help the beneficiary find a doctor for specialty care authorizations and to provide claim-processing information.

Urgent Care	Generally defined as a non-emergency illness or injury for which the beneficiary needs medically necessary treatment. But it will not result in disability or death if it is not treated immediately. This kind of illness or injury does require professional attention, and should be treated within 24 hours to avoid further complications. Some examples of such illnesses or injuries include flu, earache, urinary tract infection, vomiting and diarrhea, sprained ankle, and minor sports injuries.
Wellness/Preventive Care	Routine care with a Primary Care Manager based on history such as physicals.